Under current law, the Congressional Budget Office projects that the federal share of Medicaid payments will rise from $89 billion in 1995 to $232 billion in 2005, which represents an average annual rate of growth of 10 percent (see Table 2). The Medicaid projections developed by the Office of Management and Budget (OMB) are lower than CBO's. OMB assumed that lower-than-anticipated spending in 1994 represented a change in the program that would be sustained throughout the projection period. By contrast, CBO projects that growth will return to more historical levels.

Four factors drive CBO's projections of Medicaid expenditures for the next several years: growth in beneficiaries, price increases, disproportionate share payments, and residual growth. The contribution of those factors to increased growth cannot be estimated with precision, in part because each factor interacts with all of the others. Moreover, the usual uncertainty associated with projections of federal spending is compounded in the case of Medicaid, in which decisions affecting federal spending are made at both federal and state levels.

TABLE 2. PROJECTIONS OF THE FEDERAL SHARE OF MEDICAID EXPENDITURES AND THE NUMBER OF BENEFICIARIES, 1995-2005 (By fiscal year)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Average Annual Growth Rate, 1995-2005 (Percent)
						Billions of Dollars						
Benefits	77	87	96	108	119	132	146	160	176	193	211	10.6
DSH Payments	9	9	9	10	10	11	11	11	11	11	12	3.2
Administration	3	4	4	5	5	6	6	7	7	8	9	10.1
Total	89	99	110	122	135	148	163	178	195	212	232	10.0
						Millions of People						
Beneficiaries	36.8	38.4	40.0	41.2	42.4	43.7	44.9	45.9	47.0	48.1	49.1	2.9
						Billions of Dollars						
Comparison of Medicaid Projections												
CBO	89	99	110	122	135	148	163	178	195	212	232	10.0
OMB	88	96	105	115	125	136	149	163	178	194	212	9.2

SOURCE: Congressional Budget Office and the Office of Management and Budget.

NOTES: Numbers may not add to totals because of rounding.

DSH = disproportionate share hospital.

Growth in Beneficiaries

The total number of Medicaid beneficiaries is expected to increase from 36.8 million in 1995 to 49.1 million in 2005. Some expansion in eligibility will occur because current law requires states to phase in coverage of poor children. However, since children are the least costly group of beneficiaries and only one age cohort is being added each year, those additions should not prompt rapid growth in expenditures. The numbers of children and pregnant women covered by the program are also likely to increase as a result of expansions initiated by states and authorized under section 1902(r)(2) of the Social Security Act. But the number and magnitude of such expansions are highly uncertain.

The growth in the number of disabled Medicaid beneficiaries is expected to exceed that of the overall number of beneficiaries--4.1 percent a year versus 2.9 percent. Such rapid growth reflects the continuing effects of the Social Security Administration's outreach to the disabled population, a broader interpretation of disability than in earlier years, and a growing number of individuals reaching ages at which a higher incidence of disability occurs. In part because of that increase in high-cost beneficiaries, about 45 percent of projected growth in overall Medicaid spending stems from increases in caseload.

Price Inflation

CBO uses various inflation factors to reflect increases in the cost of providing Medicaid services. Each state has discretion in setting payment rates for providers and in updating those rates. Those increases may use some form of the hospital market basket index, other state price inflators, state legislation, and negotiations between agencies and providers. Generally, national measures of inflation at most affect states' payment rates only indirectly, making projections of price inflation for Medicaid highly uncertain. CBO estimates that over the 1995-2005 period, changes in prices will account for approximately 30 percent of the projected increase in Medicaid outlays.

Disproportionate Share Payments

The Congress took action in 1991 to limit the use of provider taxes and donations and also to place a cap on the growth of DSH payments. The Omnibus Budget Reconciliation Act of 1993 enacted further restrictions on DSH payments. It is still too early to assess the full impact of those provisions, but DSH payments fell in 1993 and 1994 and rapid growth in the future is unlikely. CBO projects that DSH payments will increase by 5 percent a year through 1999 and then grow at 2 percent annually for the remainder of the projection period. Thus, DSH payments are

assumed to be a decreasing share of overall Medicaid expenditures over time. CBO projects that DSH payments will account for a small percentage of overall Medicaid growth during the 1995-2005 period.

Residual Growth

Finally, CBO's projections assume that all other factors combined will increase Medicaid spending by about 3 percent a year over the projection period. That residual growth factor encompasses state innovations, changes in utilization, the use of more complex technologies, changes in the benefit packages that states offer, increases in payment rates above general inflation, changes in the use of alternative financing mechanisms to generate federal dollars, and the impacts of section 1115 waivers and managed care.

Although some of those factors may be budget neutral or serve to reduce Medicaid outlays, the net effect of all of them combined accounts for about 25 percent of overall growth in Medicaid expenditures over the projection period. Three of the factors are of particular importance for federal policy: alternative financing mechanisms, section 1115 waivers, and the use of managed care.

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 limited the ability of states to generate federal matching dollars without corresponding state expenditures. But other mechanisms for achieving that goal--such as intergovernmental transfers--still exist. Quite possibly, the use of intergovernmental transfers will expand in the future or states will develop new mechanisms to draw down federal matching payments.

Several states have obtained--or are seeking--statewide demonstration waivers under section 1115 of the Social Security Act. The purposes of those waivers are generally to enroll more Medicaid beneficiaries in managed care and to expand insurance coverage to poor and near-poor population groups. Although 12 states now have waivers approved and an additional 9 states have waiver applications under review, the number of states that will actually obtain and implement waivers (and over what time period) is extremely uncertain. Some of the states that have had waivers approved, for example, are now backing away from or postponing implementation.

The implications of the waivers for projections of Medicaid outlays are further complicated by the terms and conditions of the Health Care Financing Administration (HCFA) governing budget neutrality. Any expansions of coverage under the waivers are supposed to be budget neutral. Because of the ways in which budget neutrality is defined, however, as well as the uncertainty surrounding

projections of the states' Medicaid expenditures in the absence of waivers, determining whether a waiver would indeed be budget neutral is difficult.

Many states, with the encouragement of the federal government, are also moving quickly to enroll Medicaid beneficiaries in managed care plans, both to improve access to care and to control costs. Managed care has been shown to be effective in a variety of acute care settings, but the evidence to date on the effectiveness of managed care in containing Medicaid costs is limited.[6] Moreover, most states have concentrated thus far on developing managed care options for children and nondisabled adults, and those groups account for only about one-third of Medicaid spending. It will be more difficult to develop appropriate and cost-saving models of managed care for elderly and disabled beneficiaries, who account for the bulk of Medicaid expenditures.[7] Although such models are being developed, states may find it difficult to achieve major savings from managed care in the near future.

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6. Robert E. Hurley, Deborah A. Freund, and John E. Paul, *Managed Care in Medicaid: Lessons for Policy and Program Design* (Ann Arbor, Mich.: Health Administration Press, 1993).

7. Deborah A. Freund and Robert E. Hurley, "Medicaid Managed Care: Contribution to Issues of Health Reform," *Annual Reviews of Public Health*, vol. 16 (1995), pp. 473-495.

The report of the House Budget Committee on the House budget resolution suggests that total federal Medicaid spending for the 1996-2002 period should be about $770 billion. That amount would represent a reduction of about $185 billion from CBO's projected expenditures under current law. The Senate's version of the budget resolution envisions similar amounts, suggesting a reduction in federal Medicaid spending of about $175 billion over the same period.

Those goals are ambitious. The House resolution assumes an average annual growth rate for federal Medicaid outlays of 4.5 percent between 1995 and 2002. That figure compares with an estimated 10.4 percent average annual rate of growth for the same period under current law. Recent growth rates for federal Medicaid outlays have been even higher, reaching an estimated 16.8 percent on average between 1990 and 1995.

The Congress could consider a number of programmatic and financial policies to achieve the budget resolution's federal spending levels for Medicaid. Programmatic policies could alter eligibility rules for enrollment or reduce the services covered by the program. Financial policies could alter the way in which the federal government pays for Medicaid but let the states decide whether to change eligibility rules, coverage, or the way in which services are delivered. Examples of

such policies include making reductions in the federal matching formula, imposing caps on federal matching payments to states, and providing block grants to states. Material from the House Budget Committee, for example, discusses the option of turning federal Medicaid expenditures into a block grant to the states.

Developing a specific Medicaid policy to meet the federal spending targets poses a number of issues: the extent of state flexibility in administering Medicaid, the allocation of federal funds among states, and the impacts on access to and quality of health care for the eligible population.

Giving the States More Flexibility

Although state Medicaid programs vary considerably in eligibility criteria, benefits, delivery systems, and reimbursement rates for providers, federal requirements restrict those variations. Advocates would argue that such requirements are essential to ensure access to care for the most vulnerable populations, provide some safeguards on the quality of care, and place limits on the growth of the program. Many states, however, believe that federal restrictions limit their ability to design fiscally prudent Medicaid programs to meet the health care needs of their low-income populations.

The federal government, for example, specifies which population groups Medicaid must cover and the optional groups that a state may cover if it chooses. Similarly, federal law specifies the services that must be provided as part of the Medicaid benefit package and the services that may be included at a state's option. With a few specific exceptions, services offered to all categorically needy beneficiaries must be comparable in terms of amount, duration, and scope. The benefit package must be uniform throughout the state, and beneficiaries must be free to choose their providers from among those who are qualified and agree to provide services to Medicaid beneficiaries.

Federal policy has also affected the reimbursement rates for providers. The Boren Amendment specifies that states must pay hospitals and nursing homes rates that are reasonable and adequate to meet the costs of efficiently and economically operated facilities. In addition, federal law requires that Medicaid payments to providers be sufficient to ensure access to covered services for Medicaid beneficiaries (to the extent that those services are available to the general population in the area in which they live). States must also submit annual plans to HCFA specifying their Medicaid fees for obstetric and pediatric services.

In certain circumstances, states can obtain waivers from particular federal requirements for the Medicaid program. Many states, for example, have obtained waivers to provide a broad range of home- and community-based services to elderly

and disabled beneficiaries who are at risk for institutionalization. Similarly, states have used waiver authority to develop managed care programs for selected categories of Medicaid beneficiaries. As discussed earlier, some states are now using the 1115 waiver process both to develop managed care programs and to expand Medicaid coverage to new population groups.

Although waivers have certainly given the states some flexibility to adapt their programs to changing needs and fiscal realities, the waiver process itself can be slow and cumbersome. Moreover, even with waiver authority, the requirements that states must meet are still considerable. Many governors, therefore, want the Congress to grant the states much more independence to design their own Medicaid programs.

The Congress could grant more flexibility to the states in a variety of ways. It could maintain the basic structure and entitlement features of the program, for example, but give the states the freedom to enroll beneficiaries in managed care and to contract with providers without having to obtain waivers. That type of approach would potentially allow the states to develop innovative delivery systems, while maintaining considerable federal control over eligibility for the Medicaid program.

Alternatively, states could be given a pure block grant to pay for health services to the poor, without any federal requirements. That option would essentially allow the states to design their own programs with minimal federal oversight.

Other models for block grants might place restrictions on the states and require some accountability to the federal government. The Congress could, for example, design a block grant program that required a certain minimum level of state expenditures for a state to receive its Medicaid block grant funds. Some policy-makers believe that maintaining a matching requirement would be necessary to ensure that states continued to spend their own resources for Medicaid.

Medicaid block grants could also be structured to ensure some minimum level of coverage for certain population groups. The Congress could establish, for example, separate block grants for the aged, disabled, adults, and children. Or states could be required to spend some minimum proportions of a single block grant on each of those groups. Alternatively, states might be required to spend some minimum proportion of a block grant on particular types of services. At the broadest level, for example, states might be required to allocate minimum proportions of a block grant to acute and long-term care services, or separate block grants might be established for each of those service categories.

Allocating Federal Funds Among the States

The way federal Medicaid dollars are currently distributed among the states results from interactions among a wide range of programmatic, sociodemographic, fiscal, and behavioral factors. The distribution also reflects 30 years of decisions by the federal government and the states, which vary greatly in the priorities that they place on providing health care to the poor. Consequently, any attempt to change the way federal Medicaid dollars are allocated among the states would pose both programmatic and political challenges.

Changing Medicaid from an open-ended entitlement to a program in which federal Medicaid expenditures were capped, or otherwise constrained, would inevitably raise controversial questions about how federal funds should be allocated among the states. One could surely develop allocation formulas based on such seemingly objective criteria as a state's fiscal capacity and the distribution of poor people with particular health care needs. But using those criteria, which the current federal matching formula reflects in only a limited way, could result in a major redistribution of federal Medicaid dollars among the states.

If the Congress decided to convert the Medicaid program into some form of block grant, allocation issues would probably become paramount. Both the initial

distribution of block grant funds among the states and how those amounts should grow over time would raise important policy questions.

A fundamental question for the initial allocation of a Medicaid block grant would be whether that allocation should reflect the current distribution of federal dollars among the states or whether some immediate adjustment to reflect the relative needs and resources of the states would be appropriate. Related issues would include the choice of a base year, how DSH payments should be allocated, the treatment of states with 1115 waivers, and the treatment of states that have already made aggressive efforts to control Medicaid spending by improving efficiency.

Whether the amounts allocated to individual states should grow at the same or varying rates would also be a complex and controversial policy decision. Differential growth rates would allow policymakers to reallocate Medicaid funds over time among the states to reflect varying growth rates in the states' low-income populations and other federal policy priorities. Complicating that long-term policy consideration is the question of whether Medicaid should also respond to short-term changes in the relative economic circumstances of the states. Mechanisms that would allow growth rates to vary over either the short or the long term would be much more difficult to construct than an approach based on a uniform growth rate for all of the states.

Ensuring Access to and Quality of Care

Limiting the growth of federal Medicaid expenditures would raise concerns about possible adverse impacts on access to care or the quality of care. Those issues are not new for Medicaid, but they would probably become more significant with tightening fiscal constraints. The states may be given more flexibility to manage their Medicaid programs. Under those circumstances, what the federal role--if any--should be in ensuring access and quality remains an open question.

An important consideration in determining the impact on access and quality is whether Medicaid can take advantage of competitive developments in the health care market that may help balance cost, access, and quality of acute care services. States have increasingly recognized the importance of improving the coordination of health services and the management of care as central features in meeting health care demand in a cost-effective manner. Managed care arrangements offer greater predictability in budgeting and greater control over future cost growth. They can also ensure access to care for Medicaid beneficiaries because providers have contractual obligations to provide care to those beneficiaries.

In markets where strong competition exists among providers, state Medicaid programs may find competitive bidding mechanisms effective in keeping costs down while maintaining service levels. However, providers who are paid on a capitated

basis may control the use of health services too stringently, particularly if capitation payments are low. Consequently, to ensure that state Medicaid programs purchase health services prudently, mechanisms for monitoring the services provided by health plans would probably be necessary. For that segment of the Medicaid beneficiary population whose health care needs are not extraordinary--mothers and children--competitive strategies could be effective in meeting program objectives.

How to address access and quality issues for the elderly and disabled populations in Medicaid is less clear. Per capita expenditures for elderly and disabled beneficiaries are over five times the level for adults and children. Such higher costs reflect the mix of services used by elderly and disabled Medicaid beneficiaries, which includes nursing home and other long-term care services. In addition, individuals with severe disabilities and chronic illnesses are more likely to depend on the care of specialists, even for services that would otherwise be considered primary care in nature. Managed care approaches for those populations remain under development, leaving near-term prospects for cost savings uncertain. Consequently, in terms of access to and quality of care, substantial reductions in Medicaid spending could have particularly serious implications for elderly and disabled beneficiaries.

Other strategies to maintain access to and quality of care for Medicaid beneficiaries are possible. Options include limiting covered services and shifting the

focus of the program toward prevention and primary care services. A critical choice may be whether to provide comprehensive services for a limited number of beneficiaries or to provide a more limited range of services for a broader group of beneficiaries. Those considerations, coupled with adopting new service delivery models and eliminating some restrictions on the management of services, could all factor into a redesigned Medicaid program.

CONCLUSION

Many of the nation's governors are now seeking less federal control of the Medicaid program to enable the states to meet the health care needs of their low-income populations more effectively. The desire of the states for greater flexibility plus the intent of the Congress to reduce significantly the rate of growth of federal Medicaid spending make the program ripe for change. But improving efficiency by itself almost certainly could not achieve reductions in the rate of growth of the order of magnitude being discussed. Some combination of cutbacks in eligibility, covered services, or payments to providers would probably be necessary. How to limit program growth in an appropriate way is the challenge facing the Congress and the states.

APPENDIX

STATE MEDICAID AND POVERTY DATA

TABLE A-1. STATE STATISTICS ON MEDICAID EXPENDITURES AND POVERTY, 1993

State	Total Medicaid Expenditures (In millions of dollars)	Federal Medicaid Expenditures (In millions of dollars)	Percentage of All Federal Medicaid Expenditures	Federal Matching Percentage	Poverty Population (In thousands)	Percentage of U.S. Poverty Population
Alaska	301.1	160.6	0.2	50.0	52	0.1
Alabama	1,635.9	1,170.9	1.6	71.5	725	1.8
Arkansas	1,017.8	758.0	1.0	74.4	484	1.2
Arizona	1,375.4	918.3	1.3	65.9	615	1.6
California	14,060.9	7,043.4	9.8	50.0	5,803	14.8
Colorado	1,281.1	700.5	1.0	54.4	354	0.9
Connecticut	1,992.9	999.8	1.4	50.0	277	0.7
District of Columbia	654.6	327.7	0.5	50.0	158	0.4
Delaware	251.0	126.2	0.2	50.0	73	0.2
Florida	4,861.8	2,680.7	3.7	55.0	2,507	6.4
Georgia	2,766.1	1,723.8	2.4	62.1	919	2.3
Hawaii	385.7	193.6	0.3	50.0	91	0.2
Iowa	959.0	603.8	0.8	62.7	290	0.7
Idaho	291.0	207.7	0.3	71.2	150	0.4
Illinois	4,908.1	2,461.9	3.4	50.0	1,600	4.1
Indiana	2,785.7	1,763.4	2.4	63.2	704	1.8
Kansas	1,073.4	624.5	0.9	58.2	327	0.8
Kentucky	1,823.7	1,309.3	1.8	71.7	763	1.9
Louisiana	3,906.3	2,888.3	4.0	73.7	1,119	2.8
Massachusetts	3,976.1	1,996.8	2.8	50.0	641	1.6
Maryland	1,972.2	989.8	1.4	50.0	479	1.2
Maine	827.9	511.9	0.7	61.8	196	0.5
Michigan	4,403.5	2,465.8	3.4	55.8	1,475	3.8
Minnesota	2,138.8	1,184.5	1.6	54.9	506	1.3
Missouri	2,244.6	1,356.5	1.9	60.6	832	2.1
Mississippi	1,175.2	928.9	1.3	79.0	639	1.6
Montana	328.0	235.6	0.3	70.9	127	0.3
North Carolina	2,839.0	1,875.3	2.6	65.9	966	2.5
North Dakota	258.2	188.6	0.3	72.2	70	0.2
Nebraska	560.0	344.2	0.5	61.3	169	0.4
New Hampshire	412.3	207.3	0.3	50.0	112	0.3
New Jersey	4,883.0	2,447.0	3.4	50.0	866	2.2
New Mexico	582.2	434.0	0.6	73.9	282	0.7
Nevada	389.6	205.2	0.3	52.3	141	0.4
New York	18,015.0	9,033.3	12.5	50.0	2,981	7.6
Ohio	5,161.5	3,114.7	4.3	60.3	1,461	3.7
Oklahoma	1,075.8	753.4	1.0	69.7	662	1.7
Oregon	946.8	592.3	0.8	62.4	363	0.9
Pennsylvania	6,468.0	3,599.2	5.0	55.5	1,598	4.1
Rhode Island	820.4	440.7	0.6	53.6	108	0.3
South Carolina	1,639.4	1,170.8	1.6	71.3	678	1.7
South Dakota	264.0	188.0	0.3	70.3	102	0.3
Tennessee	2,645.3	1,787.7	2.5	67.6	998	2.5
Texas	7,030.3	4,544.2	6.3	64.4	3,177	8.1
Utah	475.5	358.2	0.5	75.3	203	0.5
Virginia	1,788.5	898.0	1.2	50.0	627	1.6
Vermont	259.2	155.9	0.2	59.9	59	0.2
Washington	2,263.1	1,249.8	1.7	55.0	634	1.6
Wisconsin	2,094.0	1,269.7	1.8	60.4	636	1.6
West Virginia	1,199.7	915.6	1.3	76.3	400	1.0
Wyoming	133.1	90.0	0.1	67.1	64	0.2

SOURCES: Health Care Financing Administration, HCFA Form-64; *Federal Register*, vol. 59, no. 221 (November 17, 1994); and the 1994 Current Population Survey of the Bureau of the Census.

NOTES: Expenditures do not include administrative costs. Totals do not include U.S. territories. Expenditure data are for fiscal years. Poverty data are based on calendar years.

TABLE A-2. MEDICAID EXPENDITURES BY STATE, 1988 AND 1993 (By fiscal year)

State	Total Medicaid Expenditures, 1988 (In millions of dollars)	Total Medicaid Expenditures, 1993 (In millions of dollars)	Average Annual Rate of Growth, 1988-1993	Percentage of Total Medicaid Expenditures, 1988	Percentage of Total Medicaid Expenditures, 1993
Alaska	102.8	301.1	24.0	0.2	0.2
Alabama	466.8	1,635.9	28.5	0.9	1.3
Arkansas	428.4	1,017.8	18.9	0.8	0.8
Arizona	183.1	1,375.4	49.7	0.4	1.1
California	5,592.7	14,060.9	20.0	10.9	11.2
Colorado	480.9	1,281.1	26.1	0.9	1.0
Connecticut	834.7	1,992.9	19.0	1.6	1.6
District of Columbia	379.2	654.6	11.5	0.7	0.5
Delaware	100.9	251.0	20.2	0.2	0.2
Florida	1,524.7	4,861.8	26.1	3.0	3.9
Georgia	1,136.0	2,766.1	19.5	2.2	2.2
Hawaii	159.8	385.7	19.3	0.3	0.3
Iowa	477.1	959.0	15.0	0.9	0.8
Idaho	118.5	291.0	19.7	0.2	0.2
Illinois	1,915.0	4,908.1	20.7	3.7	3.9
Indiana	1,024.0	2,785.7	22.2	2.0	2.2
Kansas	328.9	1,073.4	26.7	0.6	0.9
Kentucky	714.2	1,823.7	20.6	1.4	1.5
Louisiana	939.4	3,906.3	33.0	1.8	3.1
Massachusetts	2,078.4	3,976.1	13.9	4.0	3.2
Maryland	931.2	1,972.2	16.2	1.8	1.6
Maine	325.4	827.9	20.5	0.6	0.7
Michigan	2,047.5	4,403.5	16.6	4.0	3.5
Minnesota	1,183.2	2,138.8	12.6	2.3	1.7
Missouri	714.7	2,244.6	25.7	1.4	1.8
Mississippi	443.9	1,175.2	21.5	0.9	0.9
Montana	152.1	328.0	16.6	0.3	0.3
North Carolina	965.7	2,839.0	24.1	1.9	2.3
North Dakota	159.6	258.2	10.1	0.3	0.2
Nebraska	240.8	560.0	18.4	0.5	0.4
New Hampshire	172.0	412.3	19.1	0.3	0.3
New Jersey	1,748.2	4,883.0	22.8	3.4	3.9
New Mexico	229.0	582.2	20.5	0.4	0.5
Nevada	96.5	389.6	32.2	0.2	0.3
New York	9,717.2	18,015.0	13.1	18.9	14.3
Ohio	2,363.5	5,161.5	16.9	4.6	4.1
Oklahoma	593.1	1,075.8	12.6	1.2	0.9
Oregon	364.6	946.8	21.0	0.7	0.8
Pennsylvania	2,544.0	6,468.0	20.5	4.9	5.1
Rhode Island	334.0	820.4	19.7	0.6	0.7
South Carolina	472.3	1,639.4	28.3	0.9	1.3
South Dakota	125.9	264.0	16.0	0.2	0.2
Tennessee	1,009.5	2,645.3	21.2	2.0	2.1
Texas	2,017.2	7,030.3	28.4	3.9	5.6
Utah	196.6	475.5	19.3	0.4	0.4
Virginia	776.3	1,788.5	18.2	1.5	1.4
Vermont	113.4	259.2	18.0	0.2	0.2
Washington	932.1	2,263.1	19.4	1.8	1.8
Wisconsin	1,139.0	2,094.0	13.0	2.2	1.7
West Virginia	315.0	1,199.7	30.7	0.6	1.0
Wyoming	46.7	133.1	23.3	0.1	0.1

SOURCE: Health Care Financing Administration, HCFA Form-64.

NOTES: Expenditures do not include administrative costs. Totals do not include U.S. territories.